MINNESOTA BOARD OF MEDICAL PRACTICE

University Park Plaza • 2829 University Avenue SE Suite 500 • Minneapolis, MN 55414-3246
Telephone (612) 617-2130 • Fax (612) 617-2166 • www.bmp.state.mn.us
MN Relay Service for Hearing Impaired (800) 627-3529

PHYSICIAN VERIFICATION OF LICENSURE

This form is for verification of all medical licenses from every U.S./Canadian board issuing any type of license including training, locum tenens, and temporary permit even if license is not current. Each Board completing the form must mail directly to the **Minnesota Board of Medical Practice**. Any fees are applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

Print Name____ SS#_________________________

Signature____ Date_________________________

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THE STATE BOARD COMPLETES THE FOLLOWING INFORMATION:

IT IS HEREBY CERTIFIED THAT: (Name of Physician)____

DATE OF BIRTH: (Month, Day, Year)____

WAS ISSUED LICENSE NUMBER:____

BY: (state)________________________________ **ON:** (Month, Day, Year)______________________________

EXPIRATION DATE: (Month, Day, Year) ____

ISSUED ON THE BASIS OF: (Exam)____

DISCIPLINARY ACTION EVERY INITIATED, PENDING, OR INVOKED*: (Yes/No)________________

EVER VOLUNTARILY RELINQUISHED MEDICAL LICENSE*: (Yes/No)__________________________

ANY DEROGATORY INFORMATION WHICH YOU CAN RELEASE*: (Yes/No)____________________

Print Name______________________________

Signature_______________________________

Title__________________________________

Date__________________________________

Phone_________________________________

*If yes, please attach letter of explanation on letterhead.
**If there is no seal, attach letter of explanation on letterhead.
NOTE TO APPLICANT: Most states charge a fee for this service.

1/02